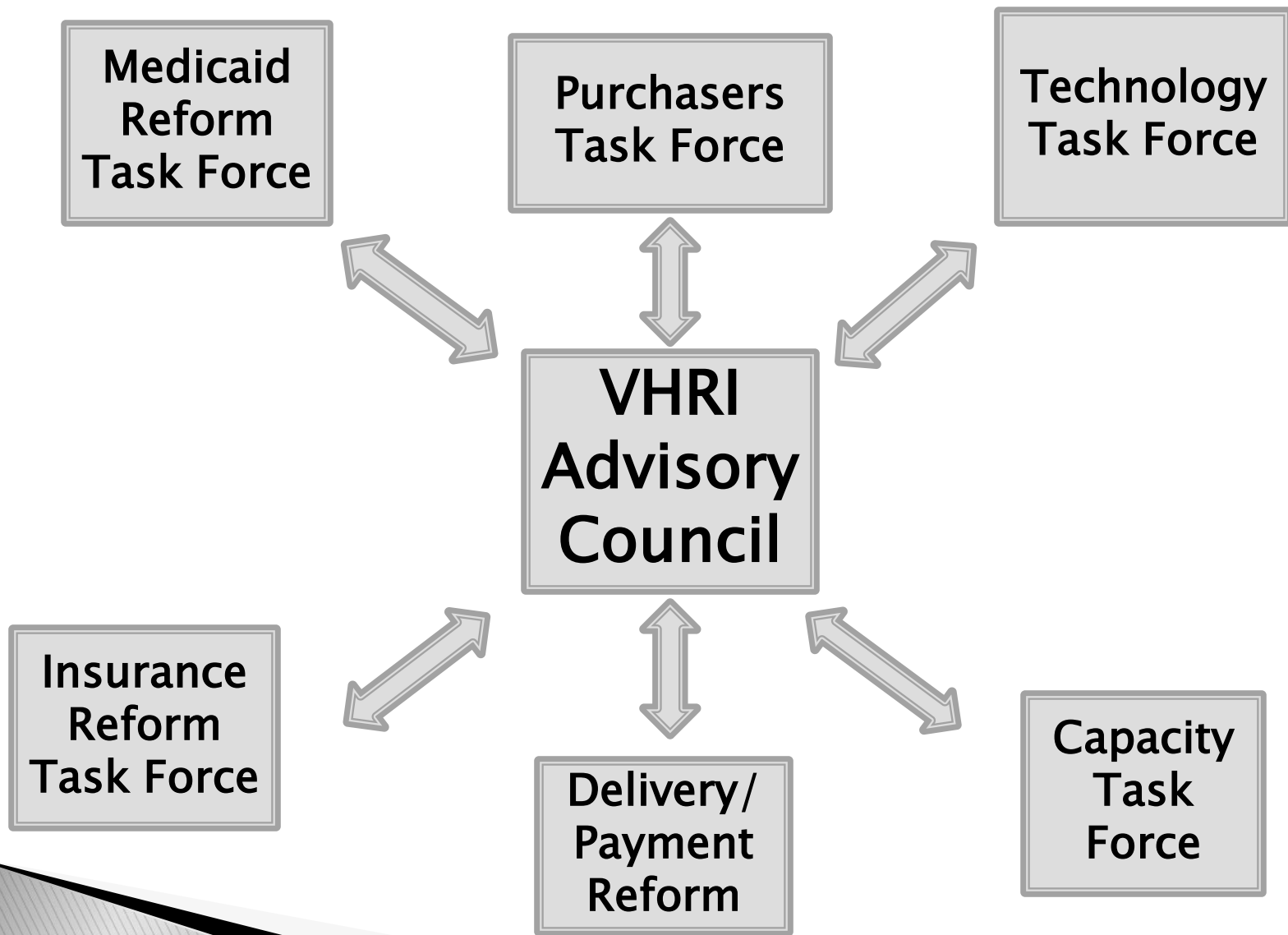


# The Virginia Health Reform Initiative

*Presentation to House Appropriations Committee  
Cindi B. Jones, Director  
Virginia Department of Medical Assistance Services,  
Virginia Health Reform Initiative*



*November 16, 2011*



# **Status Report on VHRI Advisory Council Recommendations by Task Forces**

## **Service Delivery and Payment Reform**

- ▶ Through the Virginia Chamber of Commerce, creating a private, non-profit Innovation Center to promote and spread best practices in service delivery and payment reform

## **Technology**

- ▶ Completed Broadband survey of health care providers
- ▶ Continue Health Information Technology efforts, including implementing HIT, including behavioral health
- ▶ Continue the expansion of telemedicine
- ▶ Continue work on the one stop electronic gateway to our health and human services

# Work Continues on Advisory Council Recommendations by Task Forces

## Capacity

- ▶ Through the Board of Health Professions, conducting a research project to identify barriers to safe healthcare access and effective team practice.
- ▶ Other professional groups are meeting to discuss similar issues.

## Purchaser

- ▶ Conducted focus groups and a survey to gain employers' perspective on the Exchange and health care reform in general.
- ▶ Virginia Health Care conference on June 9th, sponsored by the Virginia Chamber of Commerce; now created a Health Care Insurance Committee.

# Work Continues on Advisory Council Recommendations by Task Forces

## Insurance Reform

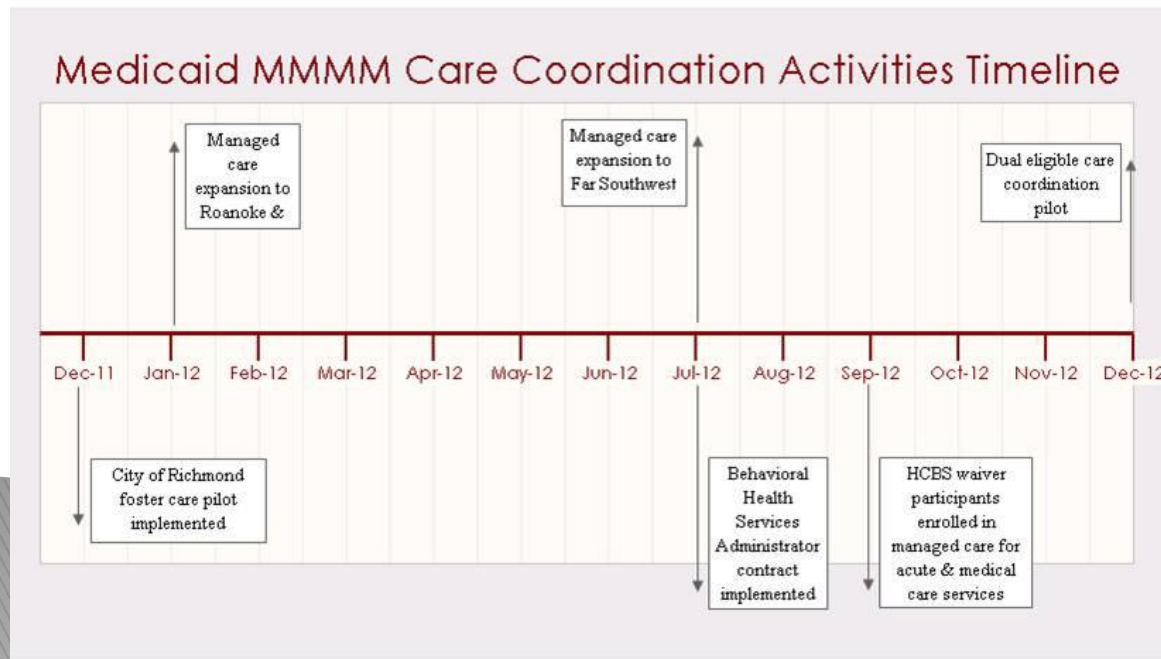
- ▶ Bureau of Insurance developed regulations to implement the insurance market legislation (HB 1958).
- ▶ Plan for Health Benefit Exchange (HB 2434).

## Medicaid

- ▶ Continue to expand Medicaid funded care coordination models as laid out in 2011 Budget language 297.1, MMMM
- ▶ Continue to implement and plan for changes to the Medicaid program as the result of federal health care reform.
- ▶ Work with other State Leaders and Congress on Potential Changes to the Current and Future Medicaid program

# Stakeholder Medicaid Reform Ideas

1. Promote Wider Adoption of Managed Care for all Beneficiaries in Medicaid.
  - DMAS is in the process of expanding principles of managed care/care coordination to all geographic areas, populations, and services as shown by the timeline below.



# Stakeholder Medicaid Reform Ideas

## 2. Extend Managed Care to Dual Eligibles.

- DMAS currently provides managed care to dual eligibles (those who are both Medicare and Medicaid eligible) through its seven Program of All Inclusive Care for the Elderly (PACE) sites; will expand to 14 sites within the next twelve months.
- In October 2011, DMAS submitted a Letter of Intent to the Centers for Medicare and Medicaid Services for the opportunity to enter into three way contracts to implement managed care acute, behavioral and long term care programs for dual eligibles in Tidewater, Richmond, and Northern Virginia. Implementation for December 2012.

# Stakeholder Medicaid Reform Ideas

## 3. Increase Home and Community Based Care Services (HCBS) for Seniors and People with Disabilities

- DMAS has a long history of providing home and community based waiver services as a quality and cost effective alternative to institutionalization. Last year, 29,817 seniors and people with disabilities were served in one of seven HCBS waivers.
- One of DMAS' current performance measures has been to increase the proportion of total long term care expenditures spent on HCBS. From 2007–2011, the proportion has grown from 36 % to 49%

## 4. Integrate Medicaid Pharmacy Benefits into Managed Care

- DMAS has always incorporated Medicaid Pharmacy Benefits as part of its capitated managed care program



# Stakeholder Medicaid Reform Ideas

## 5. Offer High Performing Medical Homes in Conjunction with Managed Care

- In the Southwest, DMAS is working with MCOs and a Federally Qualified Health Center to develop a pilot medical home.
- New RFP for Behavioral Health encourages the coordination with MCOs to allow health homes for both medical and behavioral health services.

## 6. Reduce Non-Urgent Emergency Room (ER) Visits

- MCOs utilize algorithms to identify high volume ER users, case managers, 24 hour nurse lines, and provide locations on website for after hours care
- In Fee For Service, clients who abuse the ER are placed in a client medical management program.

# Stakeholder Medicaid Reform Ideas

## 7. Prevent Hospital Readmissions through Care Transitions to Home Settings

- DMAS' MCOs follow-up with individuals and their providers after a hospitalization for mental illness in an attempt to provide appropriate care that will prevent readmissions; Virginia MCO follow-up rate exceeds the national average.
- For Fee for Service, DMAS has an RFP for a Behavioral Health Organization to perform this function for those persons not in an MCO.

## 8. Provide Continuity of Care and Coverage through 12-Month Continuous Eligibility

- DMAS agrees that this would promote continuity of care but at a high cost to the Medicaid program for capitated payments to MCOs during periods when clients are ineligible.

# Stakeholder Medicaid Reform Ideas

## 9. Encourage Use of Generic Prescription Drugs

- For MCOs, DMAS incentivizes the use of generic drugs through reductions to the pharmacy component of the capitated payment to MCOs.
- For FFS, DMAS has a mandatory generic drug requirement and has 77% utilization rate; copayments are \$3 for branded drugs, \$1 for generic.
- Under the Preferred Drug List Program, some branded drugs are preferred because the net costs to DMAS after all rebates make them cheaper; projected to save more than \$4.4 million this year.

## 10. Institute Payment Rules for Out-of-Network, Non-Emergency Services

- DMAS already has instituted this; non-participating providers are paid the Medicaid rate for any services authorized by the MCO.

# DMAS Operational Improvement Initiatives

## Eligibility Review

- ▶ DMAS has engaged CGI to provide recommendations for short-term measures to mitigate local DSS eligibility errors, including options for greater local accountability; To be completed prior to the 2012 Session
- CGI will also provide longer-term analysis to ensure the policy needs and IT infrastructure – the eligibility system under development – are aligned; To be completed by May, 2012

## Performance Audit – CGI

- DMAS has engaged CGI to review past reviews/audits to identify high-impact areas for further improvement in agency functions; To be completed prior to the 2012 Session

# DMAS Operational Improvement Initiatives

## Increased Fraud & Abuse Detection – TBD

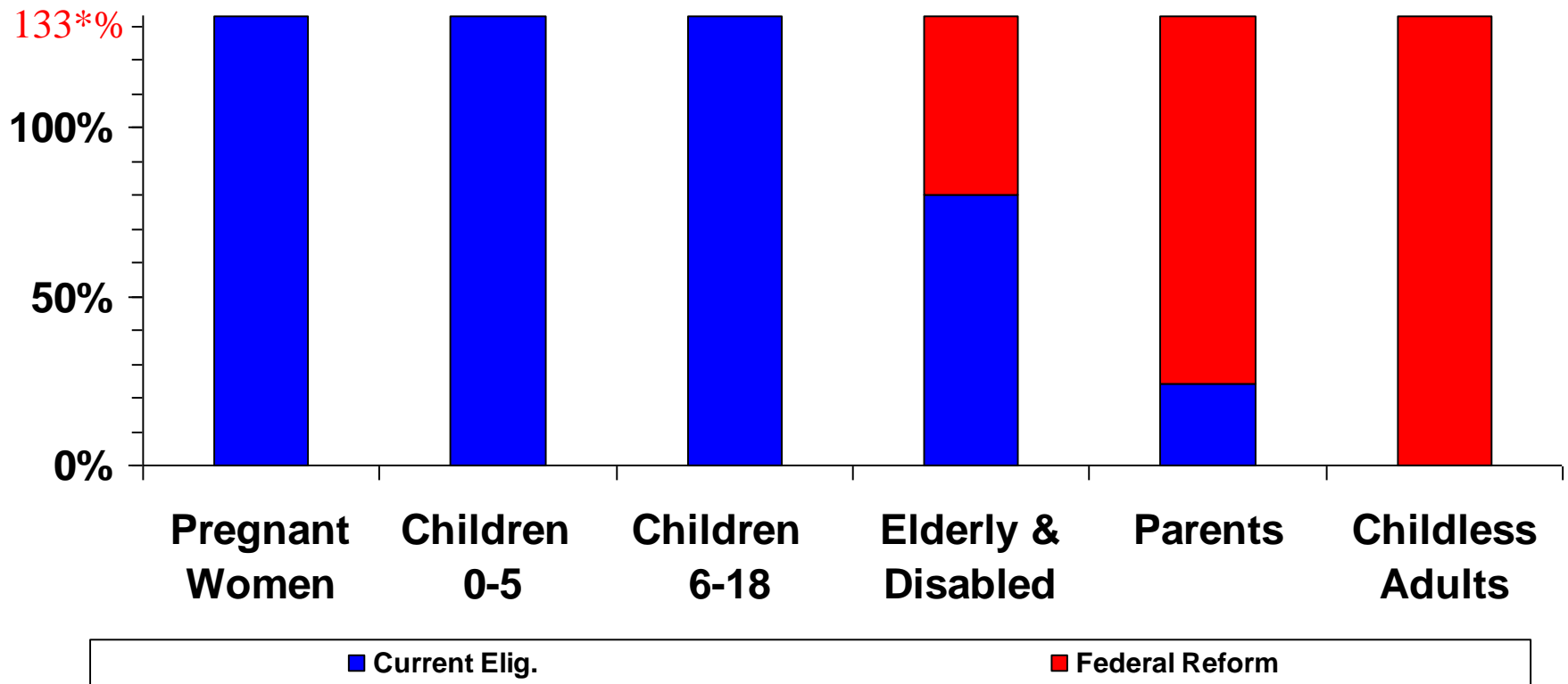
- A RFP for increased data mining is currently under review at the Office of the Attorney General and will be issued in the near future

This RFP would serve to identify additional targets for program integrity efforts through additional data analytics

- A RFP for the Recovery Audit Contractor (RAC) program is under development

This RFP would implement the federally mandated RAC program utilizing contractors under contingency contracts to enhance program integrity activity

# Federal Health Reform: Impact on DMAS Medicaid Eligibility



\*Does not include 5% income disregard;  
133% of federal poverty is \$14,404 for an individual and \$29,327  
for family of four (in 2010)

# Planning for a Health Benefit Exchange (HB2434)

A Health Benefit Exchange (HBE) is the new marketplace for small group and individual insurance. The intent of the HBE is to: improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions.

# House Bill 2434

- ▶ Directed the Secretary of Health and Human Resources and the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and general stakeholders to provide recommendations to the Governor by October 1, 2011, for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange.
- ▶ Requires, at a minimum, that it meet the relevant requirements of the PPACA



# Questions for A Health Benefit Exchange

Based on the HB 2434 legislation, the recommendations should address at a minimum:

1. Whether to create the Exchange within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;
2. The make-up of the governing board for the Exchange;
3. An analysis of resource needs and sustainability of such resources for the Exchange;
4. A delineation of specific functions to be conducted by the Exchange; and
5. An analysis of the potential effects of the interactions between the Virginia Exchange and relevant insurance markets or health programs, including Medicaid

# Virginia's Process for Planning

- **Three meetings of the full Advisory Council (Task Force Members provided input)**
  - May 26, 2011
  - July 15, 2011
  - September 9, 2011
  
- **Public Comment:**
  - Written public comment on three memorandums on governance and other HBE topics
  - Oral public comments at meetings

# Outside Expertise/Consultants Utilized

- ▶ **Alan Newman Research (ANR):** conducted eight focus groups and completed a representative survey (1,200) of small and medium Virginia based employers.

## *Findings:*

- Most are concerned about the cost of health insurance and health care
- Less than 20% are skeptical that government can or will do much to improve the level of un-satisfaction in the insurance market
- Most were supportive of the role agents play now and hope they can continue their role in the future
- Employers expressed a desire to have choice over what products their workers could have access to
- Employers expressed interest in low cost wellness programs that are currently unaffordable

# Outside Expertise/Consultants Utilized

**Price–Waterhouse Coopers (PWC):** drew upon their experience in Virginia and other insurance markets to help explain the importance of: stable risk pools both in and outside of a Health Benefit Exchange, facilitating competition and market performance regarding price and quality from the perspective of purchasers, employers, and citizens.

**The Urban Institute:** selected to do econometric modeling for at least 13 other states and used Virginia–specific survey data sets. Provided valuable information, of greatest interest is the coverage change between today (2011) and with the implementation of anticipated reforms in 2014.

	2011	2014	change
Uninsured	1,041,000	515,000	-526 ,000
Medicaid/FAMIS	1,245,000	1,665,000	+ 420,000
Private non-group	312,000	352,000	+ 40,000
Private group	4,331,000	4,397,000	+ 66,000

# Where to House a Possible HBE ?

## Options

1. An existing state agency, such as the Department of Medical Assistance Services or the State Corporation Commission;
2. A new state agency that could report to the Governor, Secretary of Health and Human Services, or other Cabinet level Secretary;
3. Quasi governmental entity, similar to the Virginia Housing Development Authority (VHDA); or
4. A not for profit private entity, similar to the Virginia Health Quality Center (VHQC).

**Majority vote:** 11–3 (2 abstentions) in favor of establishing a quasigovernmental agency with a governing board.

# The Make-up of the Governing Board for a HBE

## Recommended Governance Considerations

- The Governance structure will have the administrative flexibility in hiring, compensation, procurement, and transparency
- The Executive Director will be hired by the Governing Board/Advisory Committee
- Conflict of interest guidelines should follow existing state guidelines
- Members will be appointed to the Board/Committee by the Governor and the General Assembly
- The size of the membership be from 11 to 15, with staggered terms of two years, not to exceed four consecutive years
- The Board/Committee should include the Secretary of Health and Human Resources as an ex-officio member.

# An Analysis of Resource Needs and Sustainability of Resources for a HBE

- ▶ The VHRI Advisory Council did not have the opportunity to discuss resources needed for a HBE. This information will be provided at a later date
- ▶ However, one of the key policy options for minimizing adverse selection is to ensure broad funding for the HBE functions.
- ▶ The costs of these functions need to be covered by assessments or user fees to participating insurers in the Exchange, state funds, or some other source.
- ▶ If state agencies, such as the State Corporation Commission's Bureau of Insurance or Medicaid, absorb Exchange functions that are above and beyond their existing functions, some these costs may also need to be allocated from the funding mechanism.

# A Delineation of Specific Functions to be Conducted by a HBE

While a governance structure would have overall responsibilities for a HBE, many operational tasks could be performed by existing agencies and/or through the private sector.

## The VHRI Advisory Council identified that Virginia:

- ▶ Should utilize existing Exchange entities to the extent possible to avoid duplication and costs of setting up an Exchange;
- ▶ Should conduct Medicaid eligibility determinations for the Exchange through DMAS, also acknowledging the work of Health and Human Resources and affiliated secretariats through the development of a one stop system for Medicaid enrollment; and,
- ▶ Through the Bureau of Insurance, should potentially conduct HBE functions that are within their current mission and that the HBE or other state agencies should assume roles that are not.



# An Analysis of the Potential Effects of the Interactions Between a Virginia HBE and Relevant Insurance Markets or Health Programs, Including Medicaid.

## Key Considerations

- Have one administrative structure for a HBE, but two separate risk pools, one for individuals and one for small groups;
- Have the same insurance market rules both inside and outside of a HBE;
- Have the same state mandates inside and outside of a HBE;

# An Analysis of the Potential Effects of the Interactions Between a Virginia HBE and Relevant Insurance Markets or Health Programs, Including Medicaid.

## Key Considerations (cont.)

- Allow both agents and navigators to have a role in the HBE;
- Design the HBE to be a “passive purchaser” model by allowing all qualified health plans to participate, but in the event of extreme adverse selection, allow the Board, with approval of the Governor, to make temporary adjustments to stabilize the market; and,
- Set the parameters of what decisions should be determined by the legislature, the Board, and the Executive Director.

# Timeline for Exchange

## ▶ September 2010

- Virginia receives a one year planning grant for strategic planning for development of an Exchange

## ▶ April 2011

- HB 2434 sets intent of the General Assembly to plan for the creation and operation of a health benefit exchange

## ▶ October/November 2011

- Recommendations/Options on Exchange will be presented to Governor and then to General Assembly for consideration during the 2012 Session of the General Assembly

# Timeline for Exchange (continued)

- ▶ **June 2012**
  - Last opportunity to apply for federal grant to pay for establishing a state based Exchange
- ▶ **January 2013**
  - HHS approves that Virginia is willing and able to implement a grant by January 2014 (fallback is federal exchange or a federal/state partnership)
- ▶ **January 1, 2014**
  - Exchange must be operational
- ▶ **2015**
  - Exchange must be self-funded
- ▶ **2017**
  - Virginia option: Exchange can choose to add large employers

# Next Steps

- ▶ Governor will consider the recommendations put forth by the Virginia Health Reform Initiative Advisory Council
- ▶ Policies will be considered and options identified as to how best prepare the Commonwealth to meet federal expectations regarding a Health Benefits Exchange

# Questions?

**Information on the Virginia Health Reform Initiative's health benefit exchange meetings, other activities and reports can be found at:**

<http://www.hhr.virginia.gov/Initiatives/HealthReform/>